

MANAGEMENT ILLUSTRATED

EFFECTIVE PRACTICES IN STATE MEDICAID PROGRAMS

STATE AGENCY

Department of Social and Health Services—Division of
Medical Assistance—Washington

TOPIC

Shortcuts in Medicare/Medicaid Crossover Claims
Process

BACKGROUND

The Department of Social and Health Services (DSHS) has 240,000 clients eligible for medical assistance under the Medicaid program with 45,000 of these, roughly 20%, on State buy-in under Medicare. The volume of claims reflecting health services to Medicare and Medicaid eligibles, particularly where dual benefits are present, requires close coordination and simplification of procedures. The State of Washington has traditionally required a denial from the Medicare contractor before processing any claim for services rendered to a potential Medicare beneficiary. Under this requirement, approximately 20,000 non-covered claims were subjected to multiple billing.

THE PROBLEM

The problem which this effective practice addresses is the cost and inefficiency of processing totally non-covered Medicare claims to a denial for the sole purpose of providing an audit trail for the State's Third Party Liability (TPL), when alternative and more appropriate procedures are available. For both Medicare and Medicaid, this process resulted in delayed payments to providers, unnecessary paper flow, decreased efficiency and increased costs of claims processing, and disadvantaged beneficiaries of both programs.

THE SOLUTION

In 1978, the Regional Medicare and Medicaid Bureaus initiated cooperative efforts by the State Medicaid agency and the Medicare contractors to develop a more efficient and cost effective system for handling claims subject to coverage by either or both programs. The objective was to eliminate or minimize the negative results of the former process.

The Medicare Bureau compiled a list of Medicare exclusions and specific services which have been determined to be non-covered by the Medicare program. The list, which was made available to the State, constituted an official Medicare denial to be incorporated into the State's claims processing system and the quality control policy. Claims which fall into the excluded or non-covered category can now be processed by the

State without a denial notice on a claim by claim basis. The Regional Medicare Bureau has the responsibility to update the list and apprise the State of any changes in coverage of specific items of service.

The State agreed to revise its edit for Medicare possible clients from the prior edit of age alone, (65 years or older) to the Himex/Bendex list routinely supplied by the Social Security Administration (SSA). This revision in the edit base eliminates the need to status query individuals 65 years and beyond who are not entitled to Medicare. On the other hand, it avoids the possibility of "missing" a Medicare entitled individual below the age of 65 and increases the State's opportunity to identify all Medicare eligibles.

The practice assures more efficient and cost effective claims processing, simplifies and better coordinates delivery of health care to the aged and poor, eliminates inconsistency in billing instructions to providers participating in both programs, and reduces the paper flow and delay in claim processing to payment, while maintaining the integrity of both programs. A conservative estimate of administrative cost savings exceeds \$100,000 in the State of Washington. These savings are derived from provider preparation and billing costs, Medicare contractor processing costs, and the State Medicaid agency processing and information acquisition costs.

Seventy-five percent of hospital outpatient claims which the State receives for Medicare/Medicaid beneficiaries are suspended for additional development. During 1978, this represented approximately 32,400 claims. Projections indicate that at least 25 percent (8,100 claims) of this volume is suspended for Medicare denial verification in specific categories in which Medicare never makes payment. The Medicare Part B contractor denied approximately three percent (11,649) of claims for services rendered to Medicare/Medicaid beneficiaries. Based upon contractor experience and the character of the claims, these claims for excluded services or services known to be non-covered appear to have been submitted for the sole purpose of obtaining a denial. Under the new procedure, processing costs for crossover claims have been reduced by approximately 50 percent, representing cumulative administrative cost savings of about \$146,000 annually.

SUMMARY

Cooperation and coordination between Federal, State and Medicare contractor staff have effectively increased efficient processing of crossover claims in the Washington Medicaid program. In addition to substantial cost savings, payoff is realized in the areas of provider relations and beneficiary services.

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